

4693

04693

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** No.

Reg. Dist.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Harford</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bell Air</u>	LENGTH OF STAY (in this place) <u>4 years</u>	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Bell Air</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Toll Gate Road</u>		STREET ADDRESS (If rural, give location) <u>Toll Gate Road</u>	
3. NAME OF DECEASED: (Type or Print) <u>SIDONIA CHAMBERS ANDERSON</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>23</u> (Year) <u>1955</u>	
5. SEX: <u>FEMALE</u>	6. COLOR OR RACE: <u>NEGRO</u>	7. SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH: <u>MAY 3, 1872</u>
9. AGE last birthday: <u>83</u> yrs.		IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME: <u>JOHN WESLEY CHAMBERS</u>		14. MOTHER'S M maiden NAME: <u>ALICE COLLINS</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS: <u>ALICE A. CHAMBERS, Bell Air, Md</u>
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
(a) Immediate cause: <u>Cerebral vascular accident</u>			<u>4 days</u>
(b) Antecedent cause(s): <u>Hypertension Cardio Vascular Disease with arteriosclerosis</u>			<u>over 4 years</u>
(c) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last			
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>Fracture of hip 1951; Hipster Fracture 1954</u>			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Philip W. Newman</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>May 23, 1955</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>May 27, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Clarks Chapel</u>		LOCATION (City, town, or county) (State) <u>Bell Air, Md.</u>	
DATE REC'D BY LOCAL REG. <u>5-24-55</u>		REGISTRAR'S SIGNATURE <u>Philip W. Newman</u>	
24. FEDERAL DIRECTOR		FEDERAL DEPT. OF HEALTH	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





CERTIFICATE OF DEATH

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Place of death

6. Cause of death

7. Duration of illness

8. Occupation

9. Usual place of abode

10. Name of physician

11. Name of attending nurse

12. Name of informant

13. Name of registrar

14. Name of medical examiner

15. Name of coroner

16. Name of funeral director

17. Name of undertaker

18. Name of cemetery

19. Name of place of burial

BUREAU V. S.

MAY 31 1952

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4694

## CERTIFICATE OF DEATH

04695

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Hartford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Harrods Grace</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>MD Route 7, Harrods Grace</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hartford Memorial Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Alice</u> (Middle) <u>R</u> (Last) <u>Boteman</u>				(Month) <u>May</u> (Day) <u>4</u> (Year) <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>6/22/1919</u>	9. AGE last birthday <u>35</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assemblers shoe mfg</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John W. Racey</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Friend</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216 34 5219</u>		17. INFORMANT & ADDRESS	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>812X IMMEDIATE CAUSE (A) Fracture Cervical Vertebra</u>						<u>2 hrs</u>	
2. ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) _____ (C) _____							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Compound Fracture Both Bones R Leg</u>						<u>2 hrs</u>	
19a. DATE OF OPERATION <u>5-7-55</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>MD Route 7</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Harrods Grace Hartford Md.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>May 3 1955 958P M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Auto accident, antipedeatrian type</u>			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>12:05</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Lerald E Palmer</u>				M.D. Deputy Medical Examiner		DATE SIGNED <u>5/4/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/7/55</u>		NAME OF CEMETERY OR CREMATORY <u>Georges</u>		LOCATION (City, town, or county) (State) <u>Harrods Grace Md.</u>	
24. REC'D BY REGISTRAR <u>May 6 - 1955</u>		REGISTRAR'S SIGNATURE <u>G. L. Lewis</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>G. L. Lewis</u>		ADDRESS <u>Harrods Grace</u>	



CERTIFICATE OF DEATH

1955

BUREAU V. S.

MAY 9 1955

RECEIVED

RECEIVED  
MAY 10 1955  
U.S. DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
WASHINGTON, D.C.

4695

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH COUNTY <i>Harford Maryland</i> CITY OR TOWN <i>Harford</i> HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>—</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY <i>Harford</i> CITY OR TOWN <i>Harford</i> STREET ADDRESS <i>525 P. Washington</i>	
3. NAME OF DECEASED (Type or Print) <i>Eva D. Beckman</i>		4. DATE OF DEATH (Month) <i>3</i> (Day) <i>4</i> (Year) <i>1955</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>2/2/1881</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	9. AGE last birthday <i>74</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) <i>Harford, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thomas Mackin</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Clark</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT & ADDRESS <i>Mr. Donald Myler, 525 P. Washington, Harford, Md.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 151X IMMEDIATE CAUSE (A) <i>Carcinoma Stomach</i> ANTECEDENT CAUSE(S) DUE TO (B) <i>General Carcinomatosis</i> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <i>Cachexia</i>		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION <i>11/1/54</i>		19b. MAJOR FINDINGS OF OPERATION <i>Breast, Carcinoma</i>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, or injury street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>2/10, 1957</i> , to <i>3/4, 1957</i> , that I last saw the deceased alive on <i>3/4, 1957</i> , and that death occurred at <i>9 A.M.</i> from the causes and on the date stated above. SIGNATURE <i>Charles J. Fley</i> M.D. ADDRESS (Street, city, town, state) <i>Harford, Md.</i> DATE SIGNED <i>May 5/57</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		24. REC'D BY REGISTRAR	
DATE THEREOF <i>5/7/55</i>		REGISTRAR'S SIGNATURE <i>Angel Hall</i>	
NAME OF CEMETERY OR CREMATORY <i>Harford</i>		LOCATION (City, town, or county) (State) <i>Harford, Md.</i>	
25. FUNERAL DIRECTOR'S SIGNATURE <i>John</i>		ADDRESS <i>Harford, Md.</i>	
DATE <i>May 6-1955</i> <i>A. L. Lewis m. d.</i>			

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled in by the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

CERTIFICATE OF DEATH

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

BUREAU V. S.

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MASSACHUSETTS

THIS CERTIFICATE OF DEATH is to be filled out by the attending physician or the coroner, and is to be filed in the office of the Registrar of Vital Statistics, State Department of Health, Boston, Massachusetts.



4712

## CERTIFICATE OF DEATH

Reg. Dist. No. 125

1. PLACE OF DEATH COUNTY <i>Harford</i> <i>Maryland</i> CITY (If outside corporate limits, write RURAL and give nearest town) <i>Lapidum</i> TOWN <i>Lapidum</i> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY <i>Harford</i> CITY (If outside corporate limits, write RURAL and give nearest town) <i>Lapidum</i> TOWN <i>Lapidum</i> STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <i>Julia Ann Burkens</i> (First) (Middle) (Last)		4. DATE OF DEATH 5/29/55 19	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH 3/8/1872
9. AGE last birthday 83 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>	11. BIRTHPLACE (State or foreign country) <i>York Co. Pa.</i>
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>James A. Sample</i>		14. MOTHER'S MAIDEN NAME <i>Mary A. McAfee</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT & ADDRESS <i>Joseph A. Burkens Lapidum Md.</i>			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 260X IMMEDIATE CAUSE (A) <i>Diabetes Mellitus</i> ANTECEDENT CAUSE(S) DUE TO (B) <i>Acute Myocarditis</i> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Pulmonary Aneurysm</i>		INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	
21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>May 29, 1955</i> to <i>May 29, 1955</i> , that I last saw the deceased alive on <i>May 29, 1955</i> , and that death occurred at <i>11:30 A.M.</i> from the causes and on the date stated above. SIGNATURE <i>Charles J. Foley</i> M.D. ADDRESS <i>Harford, Md.</i> DATE SIGNED <i>May 31/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		24. REC'D BY REGISTRAR DATE <i>May 31-55</i> REGISTRAR'S SIGNATURE <i>A. L. Lewis M.D.</i>	
25. FUNERAL DIRECTOR'S SIGNATURE <i>Funeral Home</i>		26. ADDRESS <i>Harford, Md.</i>	

## INSTRUCTIONS

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

# CERTIFICATE OF DEATH

1918

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Signature of Physician		Signature of Registrar		Signature of Informant	
Date of Report		Place of Report		Signature of Informant	

BUREAU V. E.

JUN 1 1918

RECEIVED

MASSACHUSETTS

ANNUAL REPORT OF THE DEPARTMENT OF HEALTH FOR THE YEAR 1918  
BOSTON, MASS.  
JUN 1 1918

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4713 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 180

04698  
Reg. Dist.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Harford</b>		MARYLAND		STATE <b>Virginia</b>		COUNTY <b>Campbell</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <b>Abingdon</b>		LENGTH OF STAY (in this place) <b>instant</b>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <b>Lynchburg</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH		5. AGE last birthday:	
(First) <b>Thomas T.</b> (Middle) <b>Cunningham</b> (Last) <b>Jr.</b>				May, 17, 1955		25 yrs.	
6. SEX:	7. SINGLE, MARRIED, WIDOWED, DIVORCED.	8. DATE OF BIRTH:		9. AGE last birthday:		10. CITIZEN OF WHAT COUNTRY?	
male	white	married June, 25, 1931		25		U.S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Truck Driver		Transportation Co.,		Virginia		U.S. A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Thomas T. Cunningham				Lucy Jane Reid			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
no		226-34-5014		W.C. Falwell, Lynchburg, Virginia.			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause						3rd degree burns: entire body	
(b) Antecedent cause(s)							
(c) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
5/17/55 1A M.		While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		Auto accident, auto-accident			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED	
Harold C Palmer		M. D.		5/17/55			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Removal		5/17/55		J.E. Fauber F.H.		Lynchburg Campbell, Va.	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
May 20, 1955		Norma B. Moore		Howard K. Mc Comas & Son		Abingdon, Md.	

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MAY 10 1910

10-10-10

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4714 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04699  
Item 18 Film G182 5-27-55 ans

# CERTIFICATE OF DEATH

Reg. Dist. No. 82

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>HARFORD</b>		MARYLAND		STATE <b>MD.</b>		COUNTY <b>HARFORD</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>WHITEFORD</b>			
X TOWN <b>WHITEFORD</b>		<b>18 yrs.</b>		STREET ADDRESS (If rural give location) <b>WHITEFORD</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
(First) (Middle) (Last) <b>MARY OLEVA DAY</b>				<b>MAY 9 1955</b>			
5. SEX: <b>F</b>	6. COLOR OR RACE: <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>WIDOWED</b>	8. DATE OF BIRTH: <b>July 21, 1905</b>	9. AGE last birthday: <b>49</b> yrs	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life): <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>—</b>		11. BIRTHPLACE (State or foreign country): <b>DELTA R.D., Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>AMOS FOUNDS</b>				14. MOTHER'S MAIDEN NAME: <b>HENRIETTA MOORE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no or unk.): <b>No</b> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.: <b>162-05-9405</b>		17. INFORMANT & ADDRESS: <b>MRS. DORIS JONES, WHITEFORD, Md.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Carcinomatosis</b>							
DUE TO <b>Primary site unknown</b>							
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <b>January 1965</b>		19B. MAJOR FINDINGS OF OPERATION: <b>Carcinomatosis</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>March 19 55</b> to <b>May 9, 1955</b> , that I last saw the deceased alive on <b>May 9, 1955</b> , and that death occurred at <b>10 A.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>Jarvis A. Hunt</b>		M.D. <b>Delta Pa</b>		DATE SIGNED <b>5/11/55</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		DATE THEREOF <b>May 12, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>SLATE RIDGE</b>		LOCATION (City, town, or county) (State) <b>DELTA, PA.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>5-13-55</b>		REGISTRAR'S SIGNATURE <b>Freddie Lowmyer</b>		24. FUNERAL DIRECTOR <b>JOHN H. HARKINS, DELTA, PA.</b>		ADDRESS	



5. **THE FUTURE OF THE FIRM**

01/10/2013

**1**  
**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4715

## CERTIFICATE OF DEATH

04700

Reg. Dist. No. 181

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Aberdeen</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore 12</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>US Army Hospital</u> <u>Aberdeen Proving Ground</u>		STREET ADDRESS (If rural give location) <u>505 Cedarcroft Road</u>					
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Charles Edward Nicholas</u> <u>DIMLING</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>May 18 1955</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>September 14, 1912</u>	<b>9. AGE last birthday</b> <u>42</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Safety Engineer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>US Government</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Charles Dimling</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Catherine Miller</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>Yes</u> <u>II</u> <u>Army</u>		<b>16. SOCIAL SECURITY NO.</b> <u>042-01-5995</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mr Haines</u> <u>Civ Pers Br Aberdeen PG, Md</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<u>4201</u> IMMEDIATE CAUSE (A) <u>Infarction myocardium</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>5/1</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE</b> (Home, farm, factory, of INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>May 18</u> , 19 <u>55</u> , <b>to</b> <u>May 18</u> , 19 <u>55</u> , <b>that I last saw the deceased</b> <u>alive on</u> <u>May 18</u> , 19 <u>55</u> , <b>and that death occurred at</b> <u>9:18aM</u> , <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Peter P. Mayock Jr.</u>				<b>ADDRESS</b> (Street, city, town, state) <u>US Army Hosp Aberdeen PG, Md</u>		<b>DATE SIGNED</b> <u>May 18 1955</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>5/21/55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Loudon Park Cem.</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Balto., Md.</u>	
<b>24. REC'D BY REGISTRAR</b> DATE <u>May 20, 1955</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Nellie R. Perry</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm. J. Lieberman</u>		<b>ADDRESS</b> <u>9 Louis. Balto 17</u>	

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04701

4696

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		STATE <u>Md.</u> COUNTY <u>Cecil</u>		CITY (if outside corporate limits, write RURAL and give nearest town) <u>North East</u>		TOWN <u>7x</u>	
CITY (if outside corporate limits, write RURAL and give nearest town) <u>Havre-De-Grace</u>		LENGTH OF STAY (in this place) <u>4 hrs.</u>		STREET ADDRESS (if rural give location) <u>R.D.#1</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>							
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Howard Ewing</u>				<u>May 11 1955</u>			
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 7 1871</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Road Gang</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Westley Ewing</u>				14. MOTHER'S MAIDEN NAME <u>Priscella Dowling</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or ynk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-22-0725</u>		17. INFORMANT & ADDRESS <u>Mrs. Mattie K. Ewing North East</u>			
<b>18. MEDICAL CERTIFICATION</b>				INTERVAL BETWEEN ONSET AND DEATH <u>3 wks. 5 mos.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
526x IMMEDIATE CAUSE (A) <u>Cardiac decompensation</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Bronchitis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>Jan 1954</u> , to <u>May 11, 1955</u> , that I last saw the deceased alive on <u>5/11</u> , 19 <u>55</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Oliver R. G. [Signature]</u> M.D.		ADDRESS (Street, city, town, state) <u>Rising Sun, Md.</u>		DATE SIGNED <u>5/12/55</u> (State)			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 14, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Brick meeting Burial Ground</u>		LOCATION (City, town, or county) <u>Calvert Md.</u>	
24. REC'D BY REGISTRAR <u>May 13-1955</u>		REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Tyson</u>		ADDRESS <u>Rising Sun, Md.</u>	

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4697

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u>		STATE <u>Md.</u> COUNTY <u>Hartford</u>		CITY (if outside corporate limits, write RURAL and give nearest town)		CITY (if outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Harrods Creek</u>		LENGTH OF STAY (in this place) <u>3 weeks</u>		CITY OR TOWN <u>Bel Air</u>		CITY OR TOWN <u>Bel Air</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hartford Memorial Hospital</u>		STREET ADDRESS (if rural give location) <u>Watervale Road</u>		STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (Type or Print) <u>James Parker Famous</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May 11 1955</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Nov. 22, 1873</u>	
9. AGE last birthday <u>81</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Joseph Famous</u>		14. MOTHER'S MAIDEN NAME <u>Sarah T. R. phy.</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or u.s.g.) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT & ADDRESS <u>Robert M. Oost Fullston Rd</u>		18. MEDICAL CERTIFICATION		19. DATE OF OPERATION		20. AUTO. SY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		IMMEDIATE CAUSE (A) <u>Acute Congestive Heart Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 Men</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Ch Cardio-Vascular Disease</u>		DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Unresolved lobar pneumonia</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (Second)	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>April 16</u> 1955, to <u>May 11</u> 1955, that I last saw the deceased alive on <u>May 10</u> 1955, and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson</u> M.D.		ADDRESS (Street, city, town, state) <u>Forest Hill Md</u>		DATE SIGNED <u>5/11/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 14, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		LOCATION (City, town, or county) <u>Bel Air, Md</u>	
24. REC'D BY REGISTRAR <u>5-12-56</u>		REGISTRAR'S SIGNATURE <u>Phyllis Lowndes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u>		ADDRESS <u>Bel Air, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this

date certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this

death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4716

## CERTIFICATE OF DEATH

04703

Reg. Dist. No. 180

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Harford</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Harford</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Abingdon</b>				TOWN <b>Abingdon</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <b>Marie</b>		(Middle) <b>L.</b>		(Last) <b>Fenstermacher</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>married</b>		8. DATE OF BIRTH <b>May, 21, 1909</b>	
				9. AGE last birthday <b>45</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
						Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (State or foreign country) <b>Richmond, Va.,</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>no</b> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>218-18-1825</b>		17. INFORMANT & ADDRESS <b>Daniel W. Fenstermacher, Abingdon, Md.</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
422.1 IMMEDIATE CAUSE (A) <b>Pulmonary edema</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>			
ANTECEDENT CAUSE(S) DUE TO (B) <b>Arteriosclerotic CVD disease</b>				<b>6 mo.</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Jan 10, 1955</b> to <b>May 1, 1955</b> , that I last saw the deceased alive on <b>April 30, 1955</b> , and that death occurred at <b>10:30 P.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>Harold C Palmer</b>				ADDRESS (Street, city, town, state) <b>Bel Air Md.</b>		DATE SIGNED <b>5/3/55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>May 4, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Cokesbury</b>		LOCATION (City, town, or county) (State) <b>Abingdon, Harford, Md.</b>	
24. REC'D BY REGISTRAR <b>May 4, 1955</b>		REGISTRAR'S SIGNATURE <b>Norma E. Moore</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Howard K. Mc Comas &amp; Son, Abingdon, Md.,</b>			

PLANNED V. S.

04704

4717

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Harford</b>		STATE <b>Pennsylvania</b>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <b>Aberdeen</b>		LENGTH OF STAY (In this place)		CITY OR TOWN <b>Stockertown</b>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION, OR STREET ADDRESS <b>U. S. Army Hospital Aberdeen Proving Ground</b>		STREET ADDRESS <b>30 Weona Street</b>					
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>LEWIS</b>		(Middle) <b>(NONE)</b>		(Last) <b>FLANK</b>		(Month) <b>May</b> (Day) <b>4</b> (Year) <b>19 55</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Oct 27, 1937</b>	9. AGE last birthday <b>17</b> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Soldier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Army</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Bruce Flank</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT & ADDRESS <b>Military Personnel Aberdeen Proving Ground, Md.</b>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Asphyxiation and charring of the body			
IMMEDIATE CAUSE (A) <b>916.9</b>				30 minutes			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.) <b>Barnack</b>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <b>Aberdeen Proving Ground, Harford, Md.</b>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>4 May 1955 at 7:00 A. M.</b>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>Trapped in fire</b>			
22. I hereby certify that I attended the deceased from <b>4 May</b> , 19 <b>55</b> , to <b>4 May</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>4 May</b> , 19 <b>55</b> , and that death occurred at <b>7:00AM</b> from the causes and on the date stated above.							
SIGNATURE <b>Richard Allen</b>		ADDRESS (Street, city, town, state)		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		DATE THEREOF <b>5-5-55</b>		NAME OF CEMETERY OR CREMATORY <b>Nazareth Cemetery</b>		LOCATION (City, town, or county) (State) <b>Nazareth, Penna.</b>	
24. REC'D BY REGISTRAR <b>May 5-1955</b>		REGISTRAR'S SIGNATURE <b>Mellie R. Perry</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Yarrig</b>		ADDRESS <b>Aberdeen Md.</b>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1 55 10M





4718

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Harford</u>	
CITY OR TOWN <u>Jarrettsville</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Jarrettsville</u>		Rural <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>—</u>				STREET ADDRESS (If rural give location) <u>Rocks-Rd.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MAUDIE</u> (Middle) <u>ANN</u> (Last) <u>GOOD</u>				(Month) <u>MAY</u> (Day) <u>6</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>3-12-1886</u>	9. AGE last birthday <u>69</u> Yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Labellia W. VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Silas Morrison</u>				14. MOTHER'S MAIDEN NAME <u>Manerva Crunkshank</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Grant H Good Rocks Md</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443X IMMEDIATE CAUSE (A) <u>Chronic Congestive Heart Failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Good</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardiovascular Disease</u>				<u>Sympt</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>None</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 15, 1948</u> to <u>May 6, 1955</u> , that I last saw the deceased alive on <u>May 5, 1955</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Charles G. Huff</u> M.D.				ADDRESS (Street, city, town, state) <u>Street, Md.</u> DATE SIGNED <u>May 7, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>May 7</u>		NAME OF CEMETERY OR CREMATORY <u>Bell Air Men Gardens</u>		LOCATION (City, town, or county) <u>Bell Air Md</u>	
24. REC'D BY REGISTRAR <u>—</u>		REGISTRAR'S SIGNATURE <u>Pawilia Louwood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Monter &amp; Ruth Janchen</u>			
DATE <u>5/10/56</u>							

**INSTRUCTIONS:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

HATFORD

January 16 (Wed)

HATFORD  
January 16 (Wed)  
HATFORD

MAUDIE ANN GORD

Female Hair 3-12-1885

Female Hair 3-12-1885

2102 Morris

110

Hypertension (arteriosclerotic)  
Chronic congestive heart failure  
Brain in good condition

Now

Barrel  
Made at Berlin Iron Works  
Stoughton, Mass  
April 25 1905

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO VITAL STATIST:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

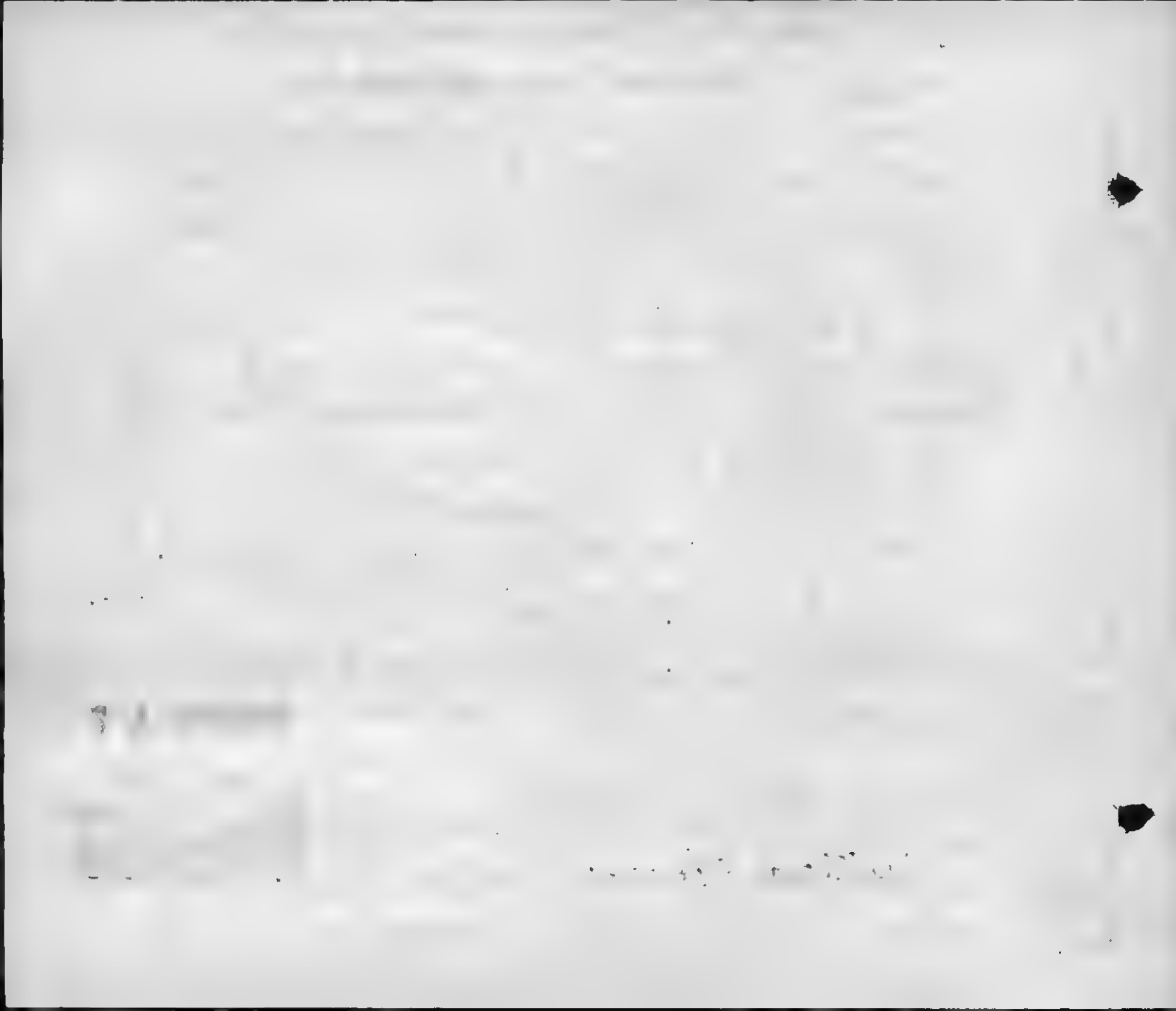
4719

## CERTIFICATE OF DEATH

04706

Reg. Dist. No. 1802

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN <u>Forest Hill</u>		7 years		OR TOWN <u>Forest Hill</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
17				1			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Llewellyn</u> (Middle) <u>@</u> (Last) <u>Hall</u>				(Month) <u>May</u> (Day) <u>14</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
M	W	Widowed	Aug 10 - 1873	81 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Farmer		Farmer		Lo		US	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Charles R Hall				Josephine Prosser			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		No		Richard A Hall Forest Hill, MD			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				Peripheral Vascular Disease (Closure popliteal art. left leg with gangrene)			
ANTECEDENT CAUSE(S) DUE TO (B)				Generalized Arteriosclerosis			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				Chr. Cardio-vascular disease			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				Pulmonary Emphysema			
				Chr. Bronchial Asthma (Occasional attacks)			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
0							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
		M. <input type="checkbox"/> <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from 1936 to 1955, that I last saw the deceased alive on May 14, 1955, and that death occurred at 6:30 P.M. from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
Willard P. Hudson, M.D. Forest Hill, Md.				5-15-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
Burial		May 17/55		Carter Methodist		Forest Hill, Harford, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 5-16-55		Priscilla Lowwood		Joseph J. Laska Belan, Md.			





4698

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

Item 6-8-55 et

1. PLACE OF DEATH COUNTY <u>Harford</u> CITY <u>Maryland</u> OR <u>Harford</u> TOWN <u>Harford</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Harford</u> CITY <u>Harford</u> OR <u>Harford</u> TOWN <u>Harford</u> STREET ADDRESS <u>Old Bag Farm</u>			
3. NAME OF DECEASED (Type or Print) <u>James</u> (First) <u>Roy</u> (Middle) <u>James</u> (Last)				4. DATE OF DEATH <u>5/31/55</u> 19			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>6/1/1886</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Henry B. James</u>				14. MOTHER'S MAIDEN NAME <u>Ida McBone</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Maryd James, Old Bag Farm</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
153X IMMEDIATE CAUSE (A) <u>Carcinoma Sigmoid</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>General Carcinomatosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Cachexia</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>1 Jan 1955</u>				19b. MAJOR FINDINGS OF OPERATION <u>as above</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>at work</u> <input type="checkbox"/> Not while at work <input type="checkbox"/>				21e. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 1, 1955</u> to <u>May 31, 1955</u> , that I last saw the deceased alive on <u>May 31, 1955</u> , and that death occurred at <u>5:00</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Harold J. Foley M.D.</u>				DATE SIGNED <u>June 6/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>6/3/55</u>		NAME OF CEMETERY OR CREMATORY <u>Green</u>	
24. REC'D BY REGISTRAR <u>G. L. Lewis M.D.</u>				REGISTRAR'S SIGNATURE <u>G. L. Lewis</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harold James, Md.</u>	
DATE <u>June 2-1955</u>				ADDRESS <u>Harford County, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

RECEIVED

1911

4699

## CERTIFICATE OF DEATH

04708

Reg. Dist. No. 185

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>HARFORD</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>HARFORD</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>HAVRE DE GRACE</u>	<u>30 YRS</u>	TOWN <u>HAVRE DE GRACE</u>	<u>24</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>336 CHIO. ST</u>		<u>336 CHIO. ST.</u>	<u>1</u>
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) (Middle) (Last)		(Month) (Day) (Year)	
<u>MARY AGUSTA JOHNSON</u>		<u>MAY 7 1953</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>FEMALE</u>	<u>BLACK</u>	<u>WIDOWED</u>	<u>JULY 16, 1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday
<u>HOUSEWIFE</u>		<u>HOME</u>	<u>71</u> yrs.
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>W. VA.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>BASSARD, RICHARDSON</u>		<u>ELSA PETERSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
<u>—</u> (If Yes, give war or dates of service)		<u>—</u>	
17. INFORMANT & ADDRESS			
<u>JOHN H. RICHARDSON</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Congestive Heart Failure</u>			
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE			
STATING UNDERLYING CAUSE LAST. DUE TO <u>Hypertensive-Arteriosclerotic Heart Disease</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
<u>—</u>		<u>—</u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
<input type="checkbox"/>		<u>—</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
<u>—</u>		<u>—</u>	
21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?	
<u>—</u>		<u>—</u>	
22. I hereby certify that I attended the deceased from <u>June 10, 1953</u> , to <u>May 7, 1955</u> , that I last saw the deceased alive on <u>April 22, 1955</u> , and that death occurred at <u>8:00 A.M.</u> from the causes and on the date stated above.			
SIGNATURE		ADDRESS (Street, city, town, state)	
<u>George J. Stansbury, M.D.</u>		<u>569 Revolution St. Havre de Grace, Md.</u>	
DATE		DATE SIGNED	
<u>May 9, 1955</u>		<u>5/7/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. REC'D BY REGISTRAR	
<u>BURIAL</u>		<u>—</u>	
DATE THEREOF		REGISTRAR'S SIGNATURE	
<u>5-10-55</u>		<u>—</u>	
NAME OF CEMETERY OR CREMATORY		25. FUNERAL DIRECTOR'S SIGNATURE	
<u>ST. JAMES</u>		<u>—</u>	
LOCATION (City, town, or county) (State)		ADDRESS	
<u>HAVRE DE GRACE MD</u>		<u>—</u>	

**INSTRUCTIONS**

**1** TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

Conducting that failure

Hypertension with accelerated heart disease

James 23 April 23

23 April 23

George J. Starnes, Jr.  
St. Louis, Mo. 23 April 23

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04704

4720

## CERTIFICATE OF DEATH

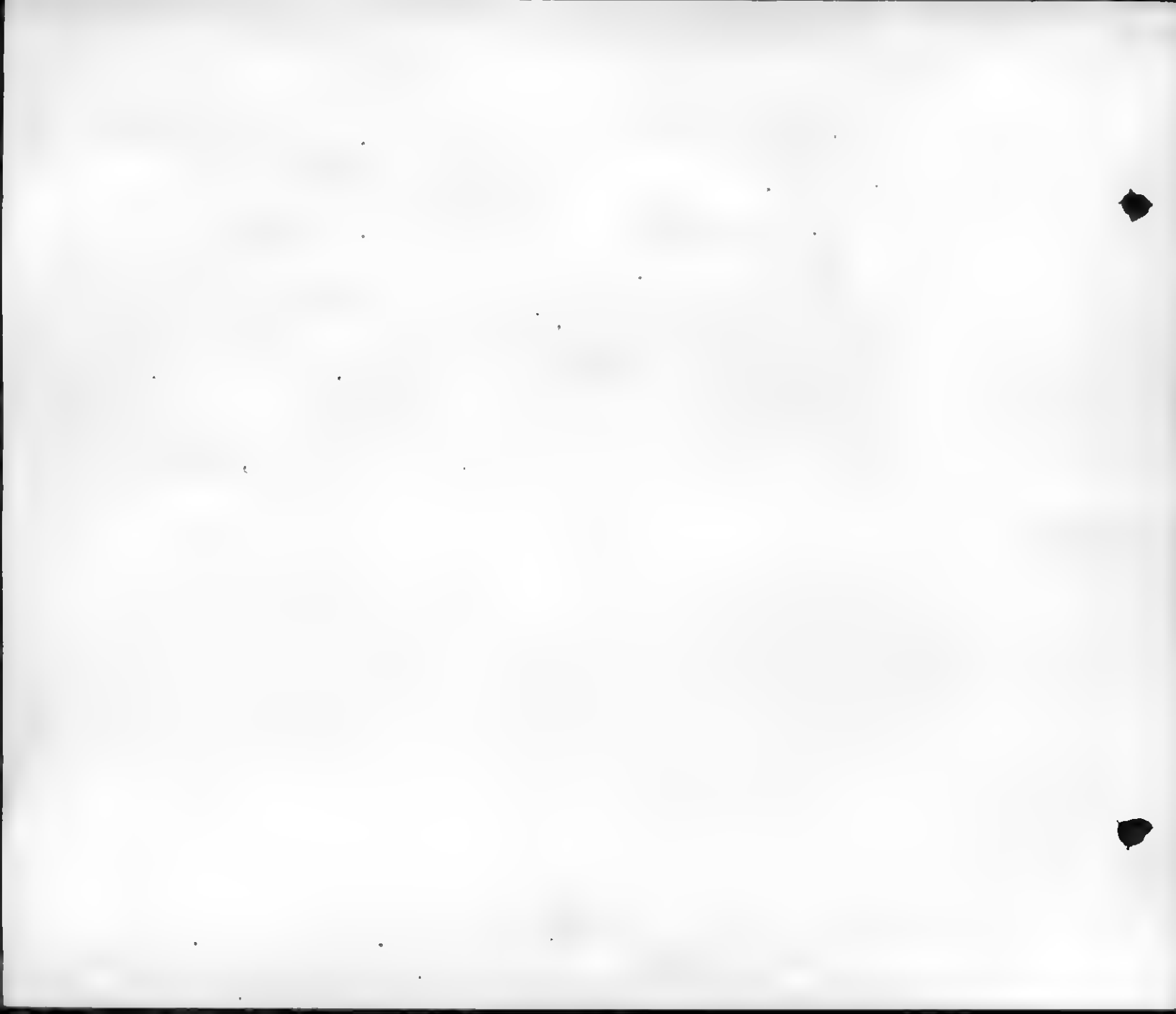
Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Harford</b>		MARYLAND		STATE <b>Md.</b>		COUNTY <b>Harford</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Joppa, Md.</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Joppa</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Rt. 2, Mountain Road</b>				STREET ADDRESS (If rural give location) <b>Rt. 2, Mountain Road</b>			
3. NAME OF DECEASED: (First) <b>EDNA</b>		(Middle) <b>A.</b>		(Last) <b>KELSO</b>		4. DATE (Month) (Day) (Year) OF DEATH: <b>May 15 19 55</b>	
5. SEX: <b>female</b>	6. COLOR OR RACE: <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <b>married</b>	8. DATE OF BIRTH: <b>Oct. 15, 1898</b>	9. AGE last birthday: <b>56</b> yrs	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>at home</b>		11. BIRTHPLACE (State or foreign country): <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>Harry Holly</b>				14. MOTHER'S MAIDEN NAME: <b>Elizabeth Smith</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <b>William Kelso, husband, above</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>CORONARY OCCLUSION</b>						<b>5 MINUTES</b>	
ANTECEDENT CAUSE (B) <b>CORONARY AND GENERALIZED</b>						<b>5 YEARS</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <b>ARTERIOSCLEROSIS</b>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>DIABETES MELLITUS</b>						<b>5 YEARS</b>	
19A. DATE OF OPERATION: <b>0 NONE</b>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>7/6</b> , 1954, to <b>5/15</b> , 1955, that I last saw the deceased alive on <b>5/14</b> , 1955, and that death occurred at <b>8 A.M.</b> , from the causes and on the date stated above.							
SIGNATURE <b>E. W. Stewart, Jr.</b>		ADDRESS <b>BOX 95 EDGEMOND MD.</b>		DATE SIGNED <b>5/16/55</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>May 18, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		LOCATION (City, town, or county) <b>Baltimore, Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>5-18-55</b>		REGISTRAR'S SIGNATURE <b>A. W. Hedrick</b>		24. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>		ADDRESS <b>2601-3-5 E. Madison St.</b>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



4721

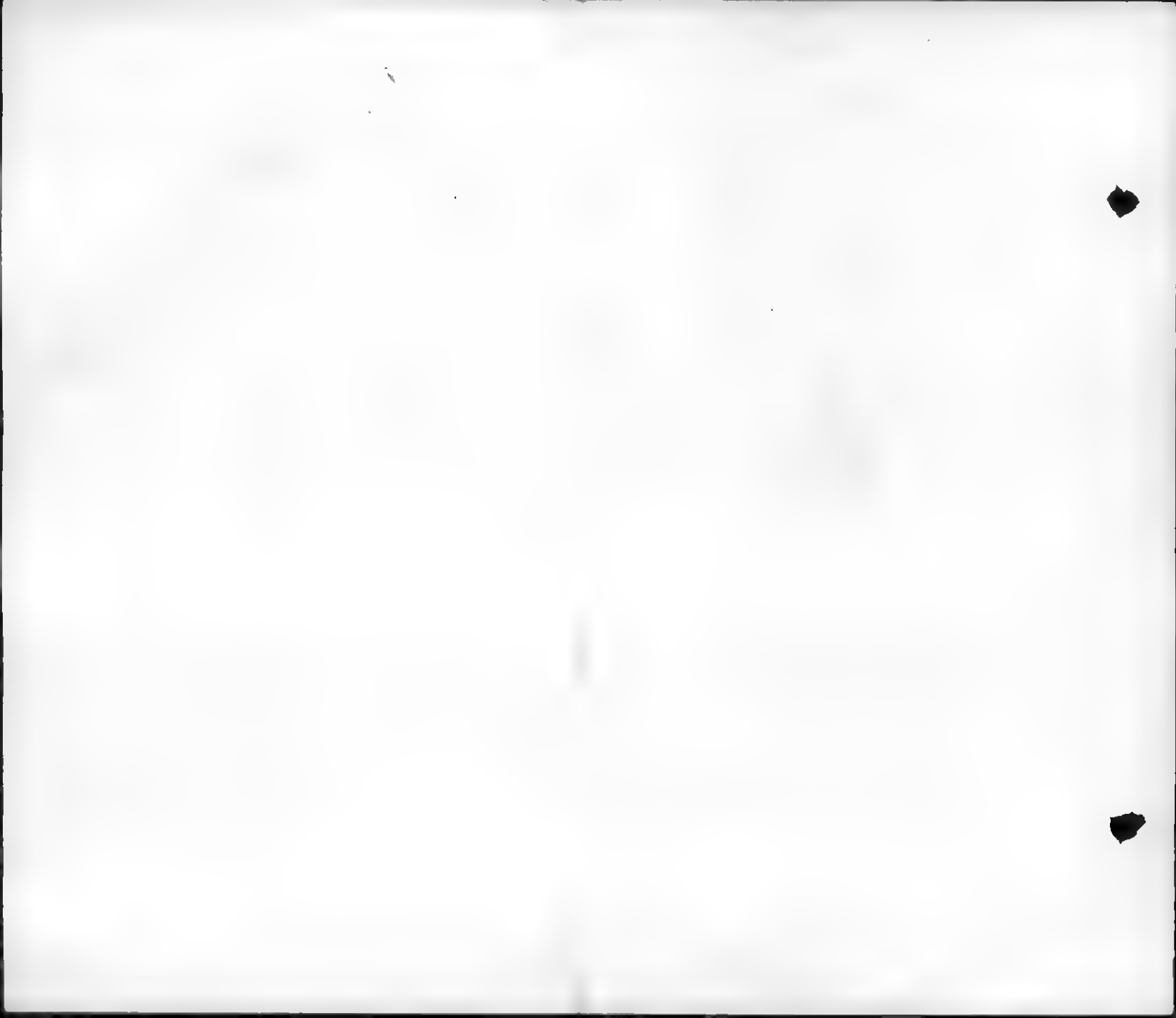
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Harpord</u> MARYLAND	STATE <u>md</u> COUNTY <u>Harpord</u>		
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>White Hall</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>White Hall</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Green Rd.</u>	STREET ADDRESS (If rural give location) <u>Green Rd. Norrisville</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)	
<u>Serge</u> <u>Levaskovich</u>		<u>May 11</u> <u>1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>June 27 1888</u>
9. AGE last birthday: <u>66</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Self</u>	
11. BIRTHPLACE (State or foreign country): <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Philip Levaskovich</u>		14. MOTHER'S MAIDEN NAME: <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Anna Posner Green Rd. Norrisville</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Carcinoma of prostate</u>		<u>4 1/2 yrs</u>	
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>May 10, 1955</u> , to <u>May 11, 1955</u> , that I last saw the deceased alive on <u>May 10, 1955</u> , and that death occurred at <u>5:39</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Edward St. Hyson</u>		DATE SIGNED <u>May 11/1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 14-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Holy Trinity Cemetery</u>		LOCATION (City, town, or county) (State) <u>Elkridge Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-13-55</u>		REGISTRAR'S SIGNATURE <u>Dr. W. H. H. H.</u>	
FUNERAL DIRECTOR <u>Dippel Bros.</u>		ADDRESS <u>1800 E. Lombard St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4722

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04711  
Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 82

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>HARFORD</b>		MARYLAND		STATE <b>MD.</b>		COUNTY <b>HARFORD</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <b>DUBLIN</b>		<b>60 YRS.</b>		TOWN <b>DUBLIN</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<b>RICHARD LAMAR McCANN</b>				<b>May 14</b>		<b>1955</b>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (State)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<b>M</b>	<b>W</b>	<b>MARRIED</b>	<b>JAN. 2, 1895</b>	<b>60</b> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<b>MERCHANT</b>		<b>RETAIL</b>		<b>YORK CO., PA.</b>		<b>U.S.A.</b>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<b>BINGLEY McCANN</b>				<b>BERTHA FREY</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.:		17. INFORMANT & ADDRESS:			
<b>No</b>				<b>HAZEL G. McCANN, DUBLIN, MD.</b>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <b>Gunshot wound cerebrum</b>							
DUE TO							
Antecedent cause(s) (b) <b>DUE TO</b>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
<input type="checkbox"/>		<b>Home</b>		<b>Dublin Harford Md.</b>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>5/14/55 1P</b>		<b>M.</b>		<b>Shot self with pistol</b>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED	
<b>Dorald C Palmer</b>						<b>5/14/55</b>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>5-16-55</b>		<b>DUBLIN</b>		<b>DUBLIN, MD.</b>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<b>5-17-55</b>		<b>Pravilla Towood</b>		<b>JOHN H. HARKINS, DELTA, PA.</b>			

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RECEIVED

4710

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 2

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 186

## 1. PLACE OF DEATH:

COUNTY

Harford

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

TOWN Harford Grace

LENGTH OF STAY (in this place)

7.07

HOSPITAL OR INSTITUTION OR STREET ADDRESS

Harford Memorial Hosp.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Maryland

COUNTY

Harford

CITY (If outside corporate limits write RURAL and give nearest town)

OR

TOWN

Aberdeen R. 77. #1 X

STREET ADDRESS

(If rural, give location)

Stepney (near)

## 3. NAME OF DECEASED:

(Type or Print)

(First)

Jesse

(Middle)

F.

(Last)

Mc Couley

## 4. DATE OF DEATH

(Month)

(Day)

(Year)

May 7

19 55

## 6. SEX:

Male

## 6. COLOR OR RACE:

White

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):

Married

## 8. DATE OF BIRTH:

June 7-1918

## 9. AGE last birthday:

41

yrs.

Months

Days

Hours

## 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

Gun tester

## 10b. KIND OF BUSINESS OR INDUSTRY:

App. Gnt.

## 11. BIRTHPLACE (State or foreign country):

Virginia

## 12. CITIZEN OF WHAT COUNTRY?

US

## 13. FATHER'S NAME:

Frank M. Couley

## 14. MOTHER'S MAIDEN NAME:

Bertha Jovel

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

## 16. SOCIAL SECURITY No.:

231-01-9372

## 17. INFORMANT &amp; ADDRESS:

Mrs Jesse F. Mc Couley - Aberdeen

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1

Immediate cause

(a).....

DUE TO

Antecedent cause(s)

Diseases or conditions, if any,

giving rise to the above cause

stating underlying cause last

(b).....

DUE TO

(c).....

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

## 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

## 21c. (City or town)

(County)

(State)

## 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

Gerald C Palmer

CHIEF MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

M. D.

ASSISTANT MEDICAL EXAM.

5/7/55

## 23. BURIAL, CREMATION, REMOVAL (Specify):

Burial

## DATE THEREOF

5/10/55

## NAME OF CEMETERY OR CREMATORY

Bel Air Memorial Gardens

## LOCATION (City, town, or county)

Bel Air, Harford Co. Md.

## DATE REC'D BY LOCAL REG.

## REGISTRAR'S SIGNATURE

John G. Tarrington

## 24. FUNERAL DIRECTOR

John G. Tarrington

## ADDRESS

Aberdeen Md.

MARGIN RESERVED FOR BINDING



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4711

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04713  
Reg. Dist.

No. 185

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Harford</i>	CITY (If outside corporate limits, write OR and give nearest town)	STATE <i>Maryland</i>	CITY (If outside corporate limits write RURAL and give nearest town)
TOWN <i>Harford</i>	LENGTH OF STAY (in this place) <i>lifetime</i>	TOWN <i>Harford</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
		<i>634 Ontario</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <i>Leveryng Joseph</i>	(Middle) <i>Mc</i>	(Last) <i>Cullough</i>	(Month) <i>May</i> (Day) <i>17</i> (Year) <i>1955</i>
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <i>Married</i>	8. DATE OF BIRTH: <i>6/17/1919</i>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY: <i>Self</i>	9. AGE last birthday: <i>35</i> yrs. <i>11</i> Months <i>11</i> Days <i>11</i> Hours <i>11</i> Min.
11. BIRTHPLACE (State or foreign country): <i>Syracuse N.Y.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Edward L. McCullough Sr.</i>		14. MOTHER'S MAIDEN NAME: <i>Myrtle M. C. Vey</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service) <i>U.S.A.</i>		16. SOCIAL SECURITY No.: <i>Unknown</i>	
17. INFORMANT & ADDRESS: <i>Margaret J. McCullough</i>		<i>634 Ontario Rd. Harford, Md.</i>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) <i>Fracture skull</i>		
DUE TO		
Antecedent cause(s) (b) <i>778X</i>		
Diseases or conditions, if any, giving rise to the above cause (c) <i>778X</i>		
DUE TO		
stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION: <i>0</i>		19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg, etc.) OF INJURY: <i>Harford Bridge</i>	21c. (City or town) (County) (State) <i>Harford Harford Md</i>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <i>5/17/55 12:15 M.</i>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>Jumped off bridge</i>
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <i>Gerald C Palmer</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>
DATE SIGNED <i>5/17/55</i>		
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>	DATE THEREOF: <i>5/20/55</i>	NAME OF CEMETERY OR CREMATORY: <i>St. Louis</i>
LOCATION (City, town, or county) (State): <i>Harford, Md.</i>	24. FUNERAL DIRECTOR: <i>James J. Lewis</i>	ADDRESS: <i>Harford, Md.</i>
DATE REC'D BY LOCAL REG: <i>May 20 - 55</i>	REGISTRAR'S SIGNATURE: <i>G. L. Lewis</i>	

JOHN A. S.

MAY 28

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04714

4723

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Harford</b>		MARYLAND		STATE <b>Md.</b>		COUNTY <b>Harford</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Rural --Darlington</b>		LENGTH OF STAY (in this place) <b>30 yrs.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Rural-- Darlington</b>		TOWN <b>Rural-- Darlington</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <b>1</b>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>MARY</b> (Middle) <b>ETHEL</b> (Last) <b>MONK</b>				(Month) <b>May</b> (Day) <b>15</b> (Year) <b>1955</b>			
5. SEX <b>Fem.</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>August 3, 1890</b>	9. AGE last birthday <b>64</b> yrs.	IF UNDER 1 YEAR Months <b>15</b> Days <b>19</b>		IF UNDER 24 HRS. Hours <b>55</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>		11. BIRTHPLACE (State or foreign country) <b>Lebanon, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Oliver Stevens</b>				14. MOTHER'S MAIDEN NAME <b>Mary Barker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT & ADDRESS <b>Bascom Monk, Darlington, Md.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>420.1 IMMEDIATE CAUSE (A) Coronary Occlusion</b>						<b>Sudden</b>	
2. ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <b>(B) Chr. Hypertensive Cardio-vascular Disease</b>						<b>1 yr.</b>	
3. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDIT ON CAUSING DEATH. <b>(C) Chr. psycho-neuritis--psychogenic arthritis</b> <b>Minimal Pulmonary Tuberculosis--quiescent</b>						<b>10 yrs.</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Dec. 1, 1935</b> , to <b>May 15, 1955</b> , that I last saw the deceased alive on <b>May 7, 1955</b> , and that death occurred at <b>11:00 p.m.</b> the causes and on the date stated above.							
SIGNATURE <b>Willard P. Hudson</b>				ADDRESS (Street, city, town, state) <b>Forest Hill, Md.</b>		DATE SIGNED <b>5-16-55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>May 19, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Mount Airy</b>		LOCATION (City, town, or county) (State) <b>Harford Co, Md.</b>	
24. REC'D BY REGISTRAR <b>May 16, 1955</b>		REGISTRAR'S SIGNATURE <b>C. A. Kiser</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>H. B. B. B. B.</b>		ADDRESS <b>Darlington, Md.</b>	

INSTRUCTIONS

1

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

BUNNELL A. E.

MAY 24 1918

RECEIVED



4702

## CERTIFICATE OF DEATH

04715

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
24 <u>Harford Place</u>		<u>1 hr. 38 Min</u>		<u>Aberdeen</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (if rural give location)			
71 <u>Harford Memorial Hospital</u>				<u>R.D. #1</u>		<u>1</u>	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Anthony Phillip</u> (Middle) <u>Myers</u> (Last)				(Month) <u>May</u> (Day) <u>2</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH <u>5-2-55</u>	
						9. AGE last birthday <u>New Born</u> <u>yes</u>	
						IF UNDER 1 YEAR Months <u>1</u> Days <u>38</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>none</u>		<u>none</u>		<u>Md</u>		<u>U S</u>	
13. FATHER'S NAME <u>Ernest Myers</u>				14. MOTHER'S MAIDEN NAME <u>Victoria Gonetest Kowalewski</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Ernest Myers, Aberdeen, R.D. Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
761.5 IMMEDIATE CAUSE (A) <u>Premature Separation Placenta</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
				21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		22. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 2</u> , 19 <u>55</u> , to <u>May 2</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 2</u> , 19 <u>55</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Charles J. Jolley</u> M.D.				ADDRESS (Street, city, town, state) <u>Harford, Md.</u> DATE SIGNED <u>5/2/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>May 3, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>St. Francis</u>		LOCATION (City, town, or county) <u>Abingdon, Harford, Md.</u>	
24. REC'D BY REGISTRAR <u>G. L. Lewis</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McComas &amp; Son</u> ADDRESS <u>Abingdon, Md.</u>			
DATE <u>May 4, 1955</u>							

VS AISC 1-55 10M

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>HARFORD</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>HARFORD</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>HAURE de GRACE</u>		TOWN <u>HAURE de GRACE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>HARFORD Memorial Hosp.</u>		<u>561 FOUNTAIN</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
<u>ELINOR</u> (First) <u>KAREN</u> (Middle) <u>Nelson</u> (Last)		5 30 19 55	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>Female</u>	<u>White</u>		<u>5-27-55</u>
9. AGE last birthday		IF UNDER 1 YEAR	
yrs. 3		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Maryland</u>		<u>U.S.A</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>Wesley Graydon Nelson</u>		<u>NORMA JEAN BAKER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS			
<u>Hospital Records</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A)		<u>RESPIRATORY FAILURE</u>	
ANTECEDENT CAUSE(S) DUE TO (B)		<u>PULMONARY HYALINE MEMORANE</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		<u>PREMATURITY -</u>	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>5-27-55</u> , 19 <u>55</u> , to <u>5-30</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-29</u> , 19 <u>55</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>ABN</u>		ADDRESS (Street, city, town, state) <u>Haure de Grace</u>	
DATE SIGNED <u>5-30-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>cremation</u>		<u>Harford Memorial Hospital</u>	
DATE THEREOF <u>5-30-55</u>		LOCATION (City, town, or county) (State)	
		<u>Haure de Grace Md.</u>	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE	
REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u>		ADDRESS <u>Haure de Grace</u>	
DATE <u>May 31-55</u>			

VS A15C 1-55 10M

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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## CERTIFICATE OF DEATH

04717

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Harford</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN <i>Barlinton Rural</i>		<i>8 yrs</i>		OR TOWN <i>Barlinton Rural</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Ida</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <i>Ida Emma Crow</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>May 4 1955</i>			
5. SEX <i>Female</i>		6. CO. OR OR RACE <i>White</i>		7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>		8. DATE OF BIRTH <i>Sept. 4 1866</i>	
9. AGE last birthday <i>88</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Calverton Co, Remm</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Isaac Lyriest</i>				14. MOTHER'S MAIDEN NAME <i>Ruth Harris</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If Yes, give year or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>		17. INFORMANT & ADDRESS <i>Geo. Crow</i>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH (A) <i>Cerebral Hemorrhage</i>				<i>3 yrs</i>			
331X IMMEDIATE CAUSE (A) <i>Antenna Sclerosis</i>				<i>3 yrs</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Myocarditis</i>				<i>3 yrs</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
19. DATE OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)			
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)				21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)			
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>3/20 1955</i> to <i>5/4 1955</i> , that I last saw the deceased alive on <i>5/3 1955</i> , and that death occurred at <i>8:30 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>F.H. Smyth</i>				ADDRESS (Street, city, town, state) <i>Barlinton Md.</i>			
DATE <i>May 8 1955</i>				DATE SIGNED <i>5/6/55</i>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>May 8 1955</i>		<i>Public Cem</i>		<i>Harford Co. Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>May 8</i>		<i>C. V. Fink</i>		<i>W. S. Bailey</i>		<i>Barlinton</i>	

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

201

1. The first part of the report is a general  
description of the area and the people who live there.

2. The second part of the report is a detailed  
description of the land and the water resources of the area.  
3. The third part of the report is a description of the  
climate and the weather of the area.  
4. The fourth part of the report is a description of the  
economy and the industry of the area.  
5. The fifth part of the report is a description of the  
education and the health of the people who live there.

S. A. 1977

6. The sixth part of the report is a description of the  
transportation and the communication of the area.  
7. The seventh part of the report is a description of the  
culture and the customs of the people who live there.

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>BEL AIR</u>		<u>10 yrs.</u>		TOWN <u>BEL AIR</u>		<u>32</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>140 Hickory AVE</u>				<u>140 Hickory AVE</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>Elizabeth K. Hardesty Richardson</u>				<u>May 26 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>W</u>	<u>WIDOWED</u>	<u>JUNE 29, 1867</u>	<u>87</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>HOUSEWIFE</u>		<u>HOUSEWIFE</u>		<u>Maryland</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Richard Clay Hardesty</u>				<u>Mary Custus Rogers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>NONE</u>		<u>Dr. Lloyd Richardson, Bel Air, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>CARDIO-RESPIRATORY FAILURE</u>						<u>ONE WEEK</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>PRECIPITATED BY HERPES ZOSTER SEVERE</u>						<u>5 WEEKS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>ARTERIOSCLEROSIS</u>						<u>"ONE YEAR"</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>19-30</u> , to <u>26 MAY</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>26 MAY</u> , 19 <u>55</u> , and that death occurred at <u>11:42</u> M., from the causes and on the date stated above.							
SIGNATURE <u>H. J. Sedwell</u>				ADDRESS (Street, city, town, state) <u>Bel Air</u>		DATE SIGNED <u>27 May 55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>MAY 28, 1955</u>		<u>GREEN MOUNT CEMETERY</u>		<u>Baltimore</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>5-27-55</u>		<u>Priscilla Lowndes</u>		<u>Foster-Funeral Home</u>		<u>Bel Air, Md.</u>	

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4705

## CERTIFICATE OF DEATH

04719

Reg. Dist. No. 185

**INSTRUCTIONS**

**1** The bottom copy may be retained by the hospital or attending physician.

**TO ATTENDING PHYSICIAN-OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>HARFORD</u>			
CITY OR TOWN <u>HAVER DE GRACE 1 MILE</u>		LENGTH OF STAY (in this place) <u>1 MILE</u>		CITY OR TOWN <u>ABERDEEN</u>		3.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD MEM. HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>214 Schmechel St.</u>			
3. NAME OF DECEASED (Type or Print) <u>IDA L. ROBINSON</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>MAY 31 1955</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>OCT 27 - 1888</u>	
9. AGE last birthday <u>66</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Theodore W. Caldwell</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Colley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>husband Walter Robinson - same add.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
6.22X IMMEDIATE CAUSE (A) <u>Uremia</u>						3 wks.	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic pyelonephritis and renal calculi</u>						10 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>—</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>—</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>—</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>May 3rd, 1955</u> to <u>May 31st, 1955</u> , that I last saw the deceased alive on <u>May 30th, 1955</u> and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edward A. Cooper, M.D.</u>		ADDRESS (Street, city, town, state) <u>420 N. Union Ave. Haver de Grace Md.</u>		DATE SIGNED <u>5/31/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/3/55</u>		NAME OF CEMETERY OR CREMATORY <u>Harmony Chapel cemetery</u>		LOCATION (City, town, or county) (State) <u>Rowlandville, Cecil Co. Md.</u>	
24. REC'D BY REGISTRAR <u>June 2-1955</u>		REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Darvany</u>		ADDRESS <u>Aberdeen Md.</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4706

Form 9, Film 1815-1-5 et

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04720

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 185

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>Del.</u> COUNTY <u>N. C.</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
TOWN <u>Harre de Chase</u>		<u>D. O. C.</u>		TOWN <u>Wilson</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hartford Mem. Hosp.</u>				STREET ADDRESS (If rural, give location) <u>1115 West St</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Mary Lou Robinson</u>				<u>May 15 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>		8. DATE OF BIRTH: <u>2/19/34</u>	
9. AGE last birthday: <u>31</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>retired</u>		11. BIRTHPLACE (State or foreign country): <u>Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Henry De Hoyos</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Pettoruto</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.: <u>1115-24750</u>			
17. INFORMANT & ADDRESS: <u>Mrs. Mary De Hoyos Wilson Del.</u>							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>F. fracture skull</u>							
DUE TO							
Antecedent cause(s) (b) <u>giving rise to the above cause</u>							
DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>5/19/55</u>				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>at home</u> )		21c. (City or town) (County) (State)			
<u>Darlington</u>		<u>Hartford</u>		<u>MD</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5/15/55 12:15 A.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Auto accident onto object type</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Gerald C Palmer</u>				M. D. ASSISTANT MEDICAL EXAM. <u>5/15/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>5/19/55</u>		NAME OF CEMETERY OR CREMATORY <u>Cathedral</u>		LOCATION (City, town, or county) (State) <u>Wilson Del.</u>	
DATE REC'D BY LOCAL REG. <u>May 15-1955</u>		REGISTRAR'S SIGNATURE <u>G. L. Lewis Jr.</u>		24. FUNERAL DIRECTOR <u>William J. Corbato</u> ADDRESS <u>Wilson Del.</u>			



## CERTIFICATE OF DEATH

04721

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u>		STATE <u>Maryland</u> COUNTY <u>Hartford</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harpe-de-Grace</u>		TOWN <u>Harpe-de-Grace</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harpe-de-Grace</u>		LENGTH OF STAY (in this place) <u>1 1/2 MRS.</u>		STREET ADDRESS (If rural give location) <u>356 Congress Ave</u>		HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hartford Memorial Hospital</u>	
3. NAME OF DECEASED (Type or Print) <u>Charlotte W Siple y.</u>				4. DATE OF DEATH (Month) <u>May</u> (Day) <u>18</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>JUNE 17 1900</u>	9. AGE last birthday <u>54</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Siple y.</u>				14. MOTHER'S MAIDEN NAME <u>ELELYN WALTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT & ADDRESS <u>Margaret Harsh, sister</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				IMMEDIATE CAUSE (A) <u>Acute Pulmonary Edema</u> <u>1 1/2 hrs.</u>			
ANTECEDENT CAUSE(S) DUE TO				(B) <u>Congestive Heart Failure - intermittent</u> <u>18 mos</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(C) <u>Congenital Heart Disease</u> <u>life</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>---</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 1952</u> to <u>May 18, 1955</u> , that I last saw the deceased alive on <u>May 18, 1955</u> , and that death occurred at <u>5:30 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Frederick J. [Signature]</u>				ADDRESS (Street, city, town, state) <u>177 N. Bird Aberdeen Md.</u>		DATE SIGNED <u>5/18/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/21-1955</u>		NAME OF CEMETERY OR CREMATORY <u>CEDAR RIDGE</u>		LOCATION (City, town, or county) (State) <u>WARREN CO. N. J.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>G. L. Lewis</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Madison [Signature]</u>		ADDRESS <u>Harpe-de-Grace, Md.</u>	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED

MAY 20 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Items 7 &amp; 11, Film 6183, 6/30/55 fcy

4725 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

047222  
Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 181

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Ohio</u>		COUNTY <u>—</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Belcamp</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town) <u>Cincinnati</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rt # 40 (South lane)</u>				STREET ADDRESS (If rural, give location) <u>—</u>			
3. NAME OF DECEASED: (First) <u>Cpl. James</u>		(Middle) <u>E.</u>		(Last) <u>Taylor</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>15</u> (Year) <u>1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>21 August 1928</u>		9. AGE last birthday <u>31</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Soldier Cpl. U.S. Army AFPM</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Irvine, Kentucky</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>May Taylor</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		(If Yes, give war or dates of service) <u>Current</u>		16. SOCIAL SECURITY No.: <u>—</u>		17. INFORMANT & ADDRESS: <u>Military Personnel Office</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>916.5</u> Immediate cause (a) <u>Second degree burns entire body</u> DUE TO Antecedent cause(s) (b) <u>—</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) <u>—</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Ante 40</u>		21c. (City or town) <u>Belcamp Harford</u> (County) <u>Me.</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5/15/55 1A</u>		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Ante caught fire</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Dorold C Palmer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5/16/55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Funeral</u>		DATE THEREOF <u>5/17/55</u>		NAME OF CEMETERY OR CREMATORY <u>Balto National</u>		LOCATION (City, town, or county) <u>Balto Md</u>	
DATE REC'D BY LOCAL REG. <u>May 17-1955</u>		REGISTRAR'S SIGNATURE <u>Mellie G. Perry</u>		24. FUNERAL DIRECTOR <u>John G. Tarring</u>		ADDRESS <u>Cherchen me.</u>	

RECEIVED

MAY 19

RECEIVED



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15B 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4708

## CERTIFICATE OF DEATH

04723

Items 8,9: film G181 5-16-55 L; also Item 22.

Reg. Dist. No. 18

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Harford</i>		STATE <i>MARYLAND</i>		COUNTY <i>Harford</i>		STATE <i>MARYLAND</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)	
TOWN <i>Harford</i>		<i>2 weeks</i>		TOWN <i>Harford</i>		<i>2 weeks</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
—				<i>251 Alliance</i>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<i>Lillian R. Todd</i>				<i>May 1 - 1955</i>			
<b>5. SEX</b>		<b>6. COLOR OR RACE</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Indicate)</b>		<b>8. DATE OF BIRTH</b>	
<i>Female</i>		<i>White</i>		<i>Widowed</i>		<i>10/6/1877 1879</i>	
<b>9. AGE last birthday</b>		<b>10. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE (State or foreign country)</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<i>75 yrs</i>		<i>none</i>		<i>Pennsylvania</i>		<i>U.S.A.</i>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MARRIED NAME</b>			
<i>Samuel Kuhn</i>				<i>Emma Kuhn</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give year or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>	
<i>no</i>				<i>none</i>		<i>Mr. Homer Daugherty 251 Alliance Harford, Md.</i>	
<b>1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>592X. IMMEDIATE CAUSE (A)</b>				<i>Cardiac Decompensation</i>			
<b>ANTECEDENT CAUSE(S) DUE TO</b>				<i>Hypertrophic Corrhosis</i>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b>				<i>Chronic Diffuse nephritis</i>			
<b>11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <i>April 22, 1955</i>, to <i>5-1-1955</i>, that I last saw the deceased alive on <i>5-1-1955</i>, and that death occurred at <i>11:00</i> M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>DATE SIGNED</b>			
<i>A. L. Lewis M.D.</i>				<i>5-4-55</i>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<i>Burial</i>		<i>5/6/55</i>		<i>Woodsboro</i>		<i>Harford, Md.</i>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
		<i>A. L. Lewis M.D.</i>		<i>Homer Daugherty</i>		<i>251 Alliance Harford, Md.</i>	
<b>DATE</b>		<i>May 3-1955</i>					



4709

## CERTIFICATE OF DEATH

04724

Reg. Dist. No. 181

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Harford</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Harford</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>31 Aberdeen</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Aberdeen</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>29 Baker Street</i>		STREET ADDRESS (If rural give location) <i>#29 Baker Street</i>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
<i>Rebecca Jeannette Wagner</i>		<i>May 29 1955</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>June 20th 1874</i>
		9. AGE last birthday <i>80</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>James B. Waheland</i>		14. MOTHER'S MAIDEN NAME <i>Susan Greenland</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT & ADDRESS <i>Gus Wagner - Aberdeen Md.</i>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
422.1 IMMEDIATE CAUSE (A) <i>Arterio Sclerotic Cardio Vascular Disease</i>			
ANTECEDENT CAUSE(S) DUE TO <i>Diabetes</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <i>Cholesterol of Arteries</i>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Cholesterol</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <i>M.</i>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>June 1, 1955</i> , to <i>May 29, 1955</i> , that I last saw the deceased alive on <i>May 29, 1955</i> , and that death occurred at <i>—</i> M., from the causes and on the date stated above.			
SIGNATURE <i>Charles J. Foley</i>		DATE SIGNED <i>May 31/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Buried</i>		24. REC'D BY REGISTRAR <i>Mellie R. Perry</i>	
DATE <i>June 1-55</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>John E. Garring</i>	
26. REGISTRAR'S SIGNATURE		ADDRESS <i>Aberdeen Md.</i>	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04725

4710

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Cecil</u>	
CITY OR TOWN <u>24 Harford Grace</u>		LENGTH OF STAY (in this place) <u>2 weeks</u>		CITY OR TOWN <u>Rising Sun</u>		<u>07X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>71 Harford Memorial Hos.</u>				STREET ADDRESS <u>R. D # 2</u>		(If rural give location)	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Calvin S. Watson</u>				<b>4. DATE OF DEATH</b> (Month) <u>May</u> (Day) <u>20</u> (Year) <u>1955</u>			
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED</b> (Specify) <u>widowed</u>		<b>8. DATE OF BIRTH</b> <u>Oct. 6, 1889</u>	
<b>9. AGE last birthday</b> <u>65</u> yrs.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>W.P.A.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Pennsylvania</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>		<b>13. FATHER'S NAME</b> <u>Samuel Watson</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Pyle</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)	
<b>16. SOCIAL SECURITY NO.</b> <u>198-09-8811</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mrs. Roland McMattey Perryville Md.</u>		<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>521X IMMEDIATE CAUSE (A)</b> <u>Brain abscess</u>				<u>2 weeks</u>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Pulmonary abscess</u>				<u>2 years</u>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>0</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>May 5, 1955</u>, to <u>May 5, 1955</u>, that I last saw the deceased alive on <u>May 20, 1955</u>, and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Neil R. Taylor</u> M.D.				<b>DATE SIGNED</b> <u>5/20/55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>				<b>24. REC'D BY REGISTRAR</b> <u>May 24, 1955</u>			
<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>A. E. Tyson</u>				<b>ADDRESS</b> <u>Rising Sun Md.</u>			

# CERTIFICATE OF DEATH

4110

NAME OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

TEMPORARY CAUSE

PREVIOUS CAUSE

PREVIOUS CAUSE

PREVIOUS CAUSE

PREVIOUS CAUSE

PREVIOUS CAUSE

PREVIOUS CAUSE

PREVIOUS CAUSE

PREVIOUS CAUSE

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PREVIOUS CAUSE

PREVIOUS CAUSE

PREVIOUS CAUSE

PREVIOUS CAUSE

PREVIOUS CAUSE

PREVIOUS CAUSE

PREVIOUS CAUSE

PREVIOUS CAUSE

BUREAU V. S.

MAY 26 1955

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

4726

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Harford</u>	
CITY OR TOWN <u>Fallston</u>		LENGTH OF STAY (in this place) <u>45 yrs</u>		CITY OR TOWN <u>Fallston</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>—</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>Blanche B. Watson</u>				4. DATE OF DEATH (Month) <u>May</u> (Day) <u>12</u> (Year) <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Aug 6<sup>th</sup> 1882</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months <u>9</u> Days <u>6</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Baldwin Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Dr. Abraham Baldwin</u>				14. MOTHER'S MAIDEN NAME <u>Martha Streett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>770-</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>James C. Watson Fallston, Md</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
571.1 IMMEDIATE CAUSE (A) <u>Prob Pulmonary Embolus</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>			
ANTECEDENT CAUSE(S) DUE TO <u>Gastro Enteritis</u>				<u>3 days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>10</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/27, 1950</u> , to <u>5/12, 1955</u> , that I last saw the deceased alive on <u>5/10, 1955</u> , and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>R. H. Barthel</u>				ADDRESS (Street, city, town, state) <u>Forest Hall Md</u>		DATE SIGNED <u>5/13/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>MAY 14 55</u>		NAME OF CEMETERY OR CREMATORY <u>Little Falls Friends</u>		LOCATION (City, town, or county) <u>Fallston Harford Md</u>	
24. REC'D BY REGISTRAR <u>5-14-55</u>		REGISTRAR'S SIGNATURE <u>Wilhelmina Lowwood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Martha Streett</u>		ADDRESS <u>Janetville Md</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this

certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this

death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



Received  
 May 17 1955  
 Bureau V. S.  
 May 17 1955  
 Bureau V. S.

RECEIVED  
 MAY 17 1955  
 BUREAU V. S.

Mr. J. W. Blanche  
 1000 1st St.  
 St. Paul, Minn.  
 James O. Watson  
 1000 1st St.  
 St. Paul, Minn.

Mr. J. W. Blanche  
 1000 1st St.  
 St. Paul, Minn.  
 James O. Watson  
 1000 1st St.  
 St. Paul, Minn.

MAY 17 1955  
 BUREAU V. S.  
 MAY 17 1955  
 BUREAU V. S.